REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, for the Coroner Area West Sussex, Brighton and Hove in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Derek Thomas BURT**, and an inquest that concluded on **02 June 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, The Association of Ambulance Chief Executives (AACE) provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE** **10 August 2026**
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: The MATTERS OF CONCERN are as follows: Overall, I accept this was an unusual set of circumstances in that the call to emergency services was made by a careline operator who was relaying information from the patient's wife who was herself the careline user and she was bedbound so not in a position to assist her husband who was bleeding heavily and non-responsive, nor could she get to a phone to answer (as it was in another room) the numerous calls made by the EMA and ambulance clinical safety navigator. That said, no one appears to have thought that the Appello careline system could have been used to speak to Mrs Burt via a third-party conference call as that is the very method used to call for help and she used it successfully, not once, but twice. I am concerned that this system and technology is utilised fully to potentially give vital clinical advice that may save future lives. 1) I heard evidence from the call centre manager of Appello Careline and the first careline operator that their system has the capability to speak directly to Mrs Burt without her pressing her wrist alarm button as this could have been done via the digital base unit that was in her bedroom. The system can also

	set up a 3 way conversation or conference call to include any of the emergency services. Indeed the operator told me she has done this in the past if asked to do so by the emergency services or she has suggested it but she did not do so in this case as she took her lead from the EMA. Conversely, I heard from a clinical safety navigator (CSN) with SECAMB that she did not know careline companies could set up 3 way conference calls for a CSN to speak to the patient or helper directly. She knew that Police and Fire Services used 3 way conference calls using careline systems but not Ambulance Trusts. This case had moved from the dispatch to the clinical stack and from the timeline of calls supplied it seems 15 calls were made between 22:52 and 23:23 to the landline and mobile numbers supplied but of course, it was impossible for Mrs Burt to answer them. No one thought to go back through the digital base unit to offer the basic clinical advice that was needed. I am concerned that both Ambulance Trusts generally as well as Careline companies may not be aware of the potential to save lives using available technology. 2) I also heard from the careline centre manager that Appello does not have any specific documentation, training material or guidance that considers calls for assistance made by the service user for people other than themselves. It was good to learn that both careline operators did respond positively to the cry for help from Mrs Burt. I remained concerned however that there is no policy or guidance available for operators to cover this type of emergency or life threatening situation and no training has yet been devised to learn from the unusual circumstances that occurred here. 3) I also remain concerned that the first careline operator did not pass on a key piece of information to the EMA, namely that the caller did not have access to a phone. Nor did she ask if the blood was spurting or dribbling. Although, it was relayed that Mrs Burt was bedbound, the EMA would not have realised that Mrs Burt couldn't get to the phone as it was in another room. In addition the first careline operator did not call the EMA back when she learned Mr Burt was non responsive and had developed breathing problems. The CSN confirmed to me that if a second call had been made at that point then the call would have been upgraded to category 1. This would have been at approx 22:50. In other words around the same time the EMA was trying to call Mrs Burt back. The clinical review was allocated at 22:55 and the second 999 call was logged at 23:15 so approximately 20-25 mins had elapsed. 4) Likewise I heard from the SECAMB CSN that she had carried out an audit of the EMA notes added to their system when speaking to the first careline operator. She did so from a clinical perspective and she discovered missing information that was given but not recorded at all namely: that there had already been 20 minutes of bleeding at the time of the first call (approx. 22:43); Mr Burt was not responding normally/groaning; and Mrs Burt was bedbound therefore could not assist Mr Burt. None of this information was

	therefore available to the CSN who carried out the clinical review. In addition I heard that the end to end review carried out by SECAMB and focused on the dispatch difficulties that existed on 14 May 2025. I appreciate that the dispatch and clinical review systems were different at that time and have now been changed but I remain concerned that the quality of note taking has not been properly checked and action taken to rectify then make improvements with any individual concerned as well as capturing learning points for others. Here vital information was missing and was needed to ensure an effective clinical review could take place and thereby ensure that the category of call response is accurate. I was told this call had been audited and was found to be 95% compliant. This also calls into question the quality of the call auditing system 5) I heard that an EMA can hold a call and speak to a CSN to get basic first aid advice or join the CSN into the call. Given the volume of blood that had already been lost in this case, I am concerned that this opportunity to give clinical advice was lost especially as the call had come in via a careline operator. 6) I was told that SECAMB is taking part in a pilot called Tortoise looking at using AI to improve the accuracy of note taking. It was unclear whether a similar scheme is being explored by careline companies or if there is effective liaison between careline companies and ambulance trusts.
4.	**DETAILS OF ACTION TAKEN,** how has the concern been addressed. [If no action is proposed please explain why here. If you feel that the response should not have been sent to you, please state this]. *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* AACE is a private company owned by the English and Welsh Ambulance NHS trusts. It exists to provide ambulance services with a central organisation that supports, co-ordinates and assists with the implementation of nationally agreed policies and guidance. It is a membership organisation representing all UK NHS ambulance services and our primary focus is the ongoing development of ambulance service provision and the improvement of patient care. AACE possess the intellectual property rights of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) UK ambulance service clinical practice guidelines (the "JRCALC guidelines"). AACE is not constituted to mandate or instruct ambulance services; however, it has national influence via the regular meetings of ambulance chief executives and chairs, along with a network of national specialist groups. With respect to the matters of concern in relation to the care of Derek Burt, AACE is not in a position to respond; the specific details relate to and should subsequently be addressed by both Appello and SECAmb.

	However, within its remit as a membership organisation for UK NHS ambulance services, AACE does share learning from PFDs across the sector. In relation to this specific PFD report, we recognise that the points of concern relate to: 1. The failure to make use of the careline facility to hold three-way calls with their user and the ambulance service (either the EMA or CSN); 2. The fact that the user not having access to a landline or mobile was not made clear to the ambulance service; 3. The absence of guidance for the careline operator on management of calls for assistance made by their user on behalf of another person; 4. The absence of key clinical details in the information passed by the careline operator to the EMA, and the failure to update SECAmb when further information on the deterioration of Mr Burt became apparent; 5. Missing information in the notes recorded by the EMA which would have aided the CSN in their clinical review of the case We will comment on each of these in turn, which we hope proves helpful although not AACE's specific remit in relation to this specific case. 1. We were unaware, at a national level, of the facility for ambulance services to hold three-way conference calls with careline operators and their users. We do consider that the use of this function would be extremely helpful in certain circumstances where there is any ambiguity as to the acuity of the clinical condition of the user / person needing assistance. AACE has shared and discussed this PFD with the ambulance service medical directors group (NASMeD) and have recommended that each ambulance service reviews their own local procedures into handling calls from telecare providers and to establish if three-way calling is available. We note Appello's response in relation to three-way calling - that they believe routinely offering this facility would not be proportionate or effective – and in the most part we would agree with this. However, we would advocate that the availability of such a facility should be made known to all ambulance services by any careline operator, so that a request to use it can be made by either party, if the need arises. We understand that Appello, and other careline operators, may not wish to introduce specific operational steps that prompt the use of three-way calling. This could be due to their concern that this may adversely affect their call handling efficiency or service availability (it would mean their operator would need to stay on the line for longer) however, we would argue that the need and ability to ensure the user receives the appropriate response in a timely manner (which may or may not be an ambulance) should be paramount in these circumstances. 2. We believe the fact that the user was unable to take a call directly from the ambulance service should not only have been made known to the EMA but should also have automatically instigated the option to have a three-way call with the user. In our view, this protocol needs to be introduced into all careline providers' operational guidance.

	3. This specific issue is not one AACE is able to offer a view upon. 4. The issue of obtaining sufficient and pertinent details from careline operators when passing calls to 999 has been a matter of concern for us for a number of years. We will address this below in additional information. 5. Missing information in records made by the EMA is unfortunate and will no doubt be addressed by SECAmb. The opportunity to reduce such errors through the use of AI is indeed being tried and tested by ambulance services now that such innovations are becoming available. Tortus is the ambient voice technology being trialled in several services, with the intention of sharing learning and evaluation across the sector. **Additional information from a national perspective:** AACE began liaising with the TSA (TSA - the voice of TEC) in 2016. The TSA is the industry body for Technology Enabled Care (TEC) services that provide support to individuals in their home using a range of technologies such as a basic pendant alarm, motion or fall detectors, or door, fire and gas sensors, that automatically contact a response centre staffed 24/7. Providers of these services vary considerably from private profit-making companies to those run by local councils; they also vary greatly in the geographic and population range they cover. At the time we began engaging with TSA, they had 350 member organisations and estimated that these telecare providers were making approximately 1.25million calls to 999 a year. This figure will no doubt have increased since then. TEC providers play a vital role in supporting the independence, health and safety of older and vulnerable people and in doing so, it is essential that they can demonstrate the quality and safety of the service they operate. However, there is currently no statutory regulation of TEC providers, which is something the TSA was lobbying the government for. Together we approached NHS England to discuss these concerns and the impact that the increasing number and variety of careline monitoring services were having on 999 demand. The absence of national regulation creates disparity in the services ultimately offered to service users. It also has the potential to increase risk to service users and place inappropriate demands on 999 services. Those telecare providers registered with the TSA are expected to adhere to a quality services framework that promotes consistently safe practices and appropriate use of ambulance services. Those organisations operating outside of the TSA framework have their own standards, which are likely to vary depending on the services they choose to provide. The aims for both our organisations, when we began working together, was to consider how we could reduce risk and improve the care of telecare users by ensuring they received the most appropriate response in a timely way. This included: encouraging telecare providers to establish their own trained and equipped response teams e.g. for people who have had a fall;

	ensuring all users provide their careline service with an up-to-date list of relatives/neighbours/wardens who have access to their property and can be contacted immediately in the event of an emergency to get to them assistance and 'eyes-on' quickly while emergency services are contacted – particularly important in the event of 'silent and false alarm' calls to avoid 999 resources being sent unnecessarily. (This would have helped immensely in the case of Mr Burt). improving and standardising the type and quality of information a careline operator asks their user when they press their alarm, to better support the clinical triage process when they contact 999 developing a decision-support tool - which underpins the interaction between the user and careline operator, assessing the level of risk and urgency to determine the appropriate response – which may include calling 999. We were able to make some steady progress with TSA colleagues prior to the COVID-19 pandemic and took some specific actions with them during the pandemic to support their users as procedures and protocols clearly had to change throughout this period. The critical element of our work with them relates to the development of a decision-support tool. TSA did not have the appropriate level of clinical governance to support this, and AACE and its members are not in a position to offer this. Following liaison with NHS England, it was agreed that this work would continue under their stewardship. In 2023 the TSA published their Decision Support Tool Guidance, and a TEC Call Handling Support Tool. AACE is not aware if there is any ongoing engagement between the TSA and NHS England.
5.	**DETAILS OF FURTHER ACTION PROPOSED** *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* AACE will re-engage with the TSA in an effort to reinforce the learning from this case and the subsequent PFD.
6.	**SIGNATURE**  [redacted], Managing Director, AACE